Brandeis University

2024 Harvard Pilgrim Health Plan Services Comparison Chart

covered Services	HMO Value Deductible	HMO Premium	PPO In-Network Benefit	PPO Out-of-Network (after deductible)	HMO HDHP/HSA
Provider Network	HPHC	HPHC	HPHC /United Health Care	none	HPHC
Out of Pocket Maximum	$2,500 for single $5,000 for family	$2,500 for single $5,000 for family	$2,500 for single $5,000 for family	$2,500 for single $5,000 for family	$2,500 for single $5,000 for single
Annual Deductible	$500 for Single $1,000 for Family	N/A	N/A	$500 for Single $1,000 for Family	$1600 for single $3200 for family
Urgent Care	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded.	Covered in full after deductible met
Emergency Room	$150 / visit	$150 / visit	$150 / visit	$150 / visit	Covered after deductible
Hospitalization	$500 per admission after deductible	Covered in full	$500 / admission	20% coinsurance	Covered after deductible
Day Surgery	$250 per surgery after ded	Covered in full	$250 per surgery	20% coinsurance after ded.	Covered after deductible
Outpatient Care - *Annual Routine Preventative Services*					
• Preventive services	Covered in full	Covered in full	Covered in full	20% coinsurance after ded.	Covered in full
• Routine physical exams (including most preventive screenings), Well-Child Care, Preventive Immunizations, Preventive Pap Smears, Preventive Mammograms & Routine Colonoscopies (Colonoscopies which include any surgical removal will not be considered preventive, and will be subject to the copay, deductible and/or coinsurance).					
• OBGYN visits	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded.	Covered after deductible
• Hearing Exam	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded.	Covered after deductible
• Allergy shots	$5 per visit	$5 per visit	$5 per visit	20% coinsurance after ded.	Covered after deductible
Non-Routine Services					
• Office Visits	$25 per visit	$25 per visit	$25 per visit	20% coinsurance after ded.	Covered after deductible
• Office Visits – Specialist	$25 per visit – referral req	$25 per visit – referral req	$25 per visit	20% coinsurance after ded.	Covered after deductible
• Diagnostic Test, Lab work	Deductible only	$25 per visit	Covered in full	20% coinsurance after ded.	Covered after deductible
• Eye Exam –HPHC network	$25 once every 12 months	$25 once every 12 months	$25 once every 12 months	20% coinsurance after ded.	Covered after deductible
• High Tech Imaging [(10)]	$75 max 2 payments per year	$75 / max 2 payments	$75 / max 2 payments	20% coinsurance after ded.	Covered after deductible
Maternity					
Prenatal/Postnatal Care (routine)	Covered in full	Covered in full	Covered in full	20% coinsurance after ded.	Covered after deductible
Office visits	$25	$25 per visit	$25 per visit	20% coinsurance after ded.	Covered after deductible
Hospitalization/Delivery	$500 / admission after ded.	Covered in full	$500 / admission	20% coinsurance after ded.	Covered after deductible

Mental & Behavioral Health or Substance Abuse Services					
Inpatient	$500 / admission after ded.	Covered in full	$500 / admission	20% coinsurance after ded.	Covered after deductible
Outpatient	$25 / visit	$25 / visit	$25 / visit	20% coinsurance after ded.	Covered after deductible
Prescriptions Drugs					
Prescriptions *(up to a 30-day supply)*	$15 – Tier I $30 – Tier II $50 – Tier III	$15 – Tier I $30 – Tier II $50 – Tier III	$15 – Tier I $30 – Tier II $50 – Tier III	Reimbursable at in network level	$15 after ded. – Tier I $30 after ded. – Tier II $50 after ded. – Tier III
Mail Order Rx Drugs *(up to a 90-day supply)*	$30 – Tier I $60 – Tier II $150 – Tier III	$30 – Tier I $60 – Tier II $150 – Tier III	$30 – Tier I $60 – Tier II $150 – Tier III	Reimbursable at in network level	$30 after ded. – Tier I $60 after ded. – Tier II $150 after ded. – Tier III
Specialty Rx Drugs	$15 – Tier I $30 – Tier II $50 – Tier III	$15 – Tier I $30 – Tier II $50 – Tier III	$15 – Tier I $30 – Tier II $50 – Tier III	Not Covered	$15 after ded. – Tier I $30 after ded. – Tier II $50 after ded. – Tier III
Prescriptions are administered by OptumRx. BIN: 610011, PCN: IXR, Group: EDHEALTH. More information available at www. Optumrx.com or 855-546-3439					
Specialized Services					
Habilitative/Rehabilitative Services					
• Short-term physical therapy • occupational therapy	$25 per visit – 60 visits per type of therapy	$25 per visit – 60 visits per type of therapy	$25 per visit – 60 visits per type of therapy	20% coinsurance – 60 visits per type of therapy	Covered after deductible 60 visits per type of therapy
• speech therapy	$25 per visit – unlimited visits	$25 per visit – unlimited	$25 per visit – unlimited	20% coinsurance – unlimited	Covered after deductible
Rehab Hospital Care Prior auth	$500 per admission after deductible -60 days per year	Covered in full – 60 days per year	$500 per admission -60 days per year	$500 per admission after deductible -60 days per year	Covered after deductible -60 days per year
Skilled Nursing Care Prior auth	$500 per admission after deductible -100 days per year	Covered in full- 100 days per year	$500 per admission -100 days per year	$500 per admission after deductible -100 days per year	Covered after deductible -100 days per year
Durable Medical Equipment (DME)/Prosthetics	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance after ded.	20% coinsurance after ded.
Hearing Aids	First $2,000 covered per ear every 36 months, 20% DME coinsurance after limit has been reached	First $2,000 covered per ear every 36 months, 20% DME coinsurance after limit has been reached	First $2,000 covered per ear every 36 months, 20% DME coinsurance after limit has been reached	20% coinsurance after ded.	Deductible, then no charge. Limited to $2,000 per hearing aid every 36 months.
Chiropractic & Acupuncture Services	$25 per visit - unlimited visits	$25 per visit - unlimited visits	$25 per visit - unlimited visits	20% coinsurance - unlimited visits	Covered after deductible